Vermont State Hospital Futures Project

Option Analysis: Newly Constructed 50 Bed Hospital

Background

In 2004, the Legislature and the administration set in motion a strategic planning process to create a comprehensive plan for the delivery of services currently provided by Vermont State Hospital (VSH) within the context of long-range planning for a comprehensive continuum of mental health care. This plan was titled the "Futures Plan". The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings that promote recovery.

VSH serves multiple functions: acute inpatient care, long term rehabilitation services, secure forensic evaluation, and secure treatment. Replacing the Vermont State Hospital requires creating a range of successor programs to provide these functions. The core of the Futures Plan proposed new investments in the essential community capacities and reconfiguring the existing 54-bed inpatient capacity at the Vermont State Hospital into a new system of inpatient, rehabilitation, and residential services for adults.

In the public dialogue over the configuration of facilities and services that would replace VSH one proposal was that Vermont consider building a new, 50 bed, free-standing state hospital. In addition, the Conceptual Certificate of Need for planning granted to the Department of Health, Division of Mental Health included evaluating the feasibility of building a new, free-standing state hospital.

Planning to evaluate multiple options for replacing VSH

Throughout the summer and fall of 2007, DMH, BGS and their consultants undertook a comprehensive review of 21 potential sites and configurations organized into 5 different models for replacing the 54 bed VSH. Included in this Inpatient Options Analysis was the construction of a new, 50 bed, free-standing state hospital. Two sites were initially considered: renovation of the site of the former Genesis Nursing Home in Morrisville and a new facility located on the grounds of the state office complex in Waterbury. The renovation option for the Morrisville site did not prove viable, so this report focuses on the option to build a new facility in Waterbury. The criteria used to evaluate all of the options follow.

Policy and Quality Criteria

- Location of the facility should be consistent with consumer & stakeholder preferences
- Site selection supports fiscal sustainability of mental health system as a whole
- Capacity to sustain optimal staffing pattern
- Location facilitates clinical integration of care
- Site configuration & staffing pattern foster flexibility in clinical programming
- Site location supports future directions of mental health services
- Experience of host facility with VSH population
- Location enhances geographic distribution of inpatient psychiatric services
- Local community supports proposed facility

Architectural Viability Criteria

- Lot size (acreage)
- Site physical characteristics
- Utilities
- Zoning/permitting
- Neighborhood
- Construction issues
- Quality of program/service supported by architectural layout

Operating Cost Criteria

- Staffing model – number of full time equivalent staff (FTE's) required
- General cost (hotel –food, housekeeping, etc.)
- Administrative cost
- Annual facility total cost
- Revenue potential by source
    - Federal Medicaid
    - Medicare
    - Third-Party Private Insurance
    - State General Fund
- Assumptions about Institution for Mental Disease (IMD) status**:**
    - Any stand-alone facility *greater than 16 beds* operated by the State would be classified as an IMD and not receive Medicaid funding
    - Any unit operated by the Brattleboro Retreat would be classified as an IMD.
    - Any unit operated by either Fletcher Allen or Rutland Regional Medical Center would be sufficiently integrated into the existing hospital and not be classified as an IMD.

Capital Cost Criteria

- Construction cost estimates
- Estimates for financing and debt service

Results of the Inpatient Options Analysis for 50-Bed Hospital

The Waterbury option for a 50 bed, free-standing new state hospital achieved low scores in terms of policy and quality criteria. The Waterbury site did prove viable for development from an architectural stand point.

The 50-bed hospital option had the highest operating and construction cost of all 21 sites and 5 models. The annual operating cost for a free-standing state-run 50 bed hospital was estimated at $27 million. The FY 10 Governor recommended budget for the current Vermont State Hospital is $23.3 million. The larger floor plan modeled in the analysis contributed to the higher estimated costs in the 50 bed facility.

The estimated capital costs to develop the Waterbury site was $87.3 million and was the highest capital costs of all sites/models evaluated, in part because it required the largest footprint. The

combined capital and operating costs for the 50-bed option were also higher than any of the other combinations of sites and configurations that created comparable numbers of beds.

The Table below shows the aggregated costs to the State (General Fund and Capital Budget) including debt service estimated for five years of operation for each Model.

Table Summary Results Optimal Sites Inpatient Options Analysis - 5 Models

	Model 1 **50-beds**	**Model 2** **48-beds**	**Model 3** **50-beds**	**Model 4** **50-Beds**	**Model 5** **53-Beds**
Aggregate 5 Year General Fund Operations + Capital Costs + Debt Service	Waterbury = $158.7M	16 beds Waterbury = $30.6M 16 beds FAHC =$26.7M 16 beds BRHC= $40.3M	32 beds FAHC= $64.5M 12 beds BRHC= $35.5M 6 beds RRMC= $10.1M	40 beds FAHC= $73.3M 6 beds RRMC = $10.1M 4 beds BRHC = $12M	15 bed SRR Waterbury= $19M 32 beds FAHC= $64.5M 6 beds RRMC= $10.1M
Total 5 Year Cost to State	$158.7M	$97.6M	$110.lM	$95.4M	$93.6M

Conclusions

This analysis led to the conclusions that a more distributed approach to replacing the VSH beds is more cost effective and efficacious from a policy point of view than creating a new 50-bed program. The cumulative five year cost to the state to build and operate the 50-bed option was estimated to be $50 M more than any of the other configurations. A distributed approach offers greater likelihood of achieving fiscal sustainability of the mental health system as a whole. In addition, the more distributed approaches offers the following advantages:

- Greater adherence to consumer concerns and preferences for facilities designed to promote recovery and re-integration of individuals into the community
- Greater likelihood of achieving integration of mental with other health conditions
- The distributed model with its focus on community based services and clinical integration of care supports the future direction of mental health services
- Greater geographic distribution of inpatient psychiatric services
- Lower operating cost and greater potential revenue generation (Medicaid and Medicare reimbursement)
- Lower capital cost

Given this analysis the policy decision was taken by the administration, with support expressed by most stakeholders, to prefer a distributed model for replacement of the VSH delivery of acute inpatient services.